



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  ALLIED MEDICAL CENTERS P.O. BOX 24809 HOUSTON, TX 77029	MFDR Tracking #: M4-10-5108-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  ACE AMERICAN INSURANCE CO Box #: 15	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Our facility has sent two status requests and a request for reconsideration, all of which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided. This is also in violation of Rule 133.304(a). The request for reconsideration and this MDR are being filed in order to comply with the requirements of **RULE §133.250(B)** and **RULE §133.305.**"

**Amount in Dispute:** \$121.00

### PART III: RESPONDENT'S POSITION SUMMARY

**The Respondent did not respond to this dispute.**

### PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
8/24/09	99213-25	$53.68 \div 36.0666 \times \$61.84 = \$92.04$	\$106.00	\$92.04
9/24/09	99080-73	Rule 129.5(i) = \$15.00	\$15.00	\$15.00
			<b>Total Due:</b>	<b>\$107.04</b>

### PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### Background

- 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- 28 Tex. Admin. Code §133.240 sets out the guidelines for medical payments and denials.
- 28 Tex. Admin. Code §129.5 sets out the guidelines for work status reports.
- 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:  
No explanation of benefits were submitted in this dispute.

#### Issues

- Did the insurance carrier pay or deny the bill for date of service 8/24/09?
- Did the requestor submit proof that the medical bill was submitted to the carrier for processing?
- Is the requestor entitled to reimbursement?

### Findings

1. Pursuant to rule §133.240(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation. The requestor did not submit any EOB's in this dispute.
2. The requestor submitted a fax confirmation receipt to the carrier dated 9/25/09 supporting that the bill with CPT codes 99213 and 99080 was originally submitted on that date and received by the carrier. The requestor also submitted a second fax confirmation receipt to the carrier dated 11/24/09 supporting that the requestor had submitted the bill again. A third fax confirmation receipt is also submitted by the requestor to the carrier dated 2/17/10 supporting that the requestor was asking for a status request on the medical billing. A fourth fax confirmation receipt dated 4/20/10 was submitted supporting a request for reconsideration. The requestor has met the burden of proof with supporting documentation that the bill was sent and received by the carrier and the carrier has not responded. In addition, the Respondent did not submit a response to this dispute. Pursuant to rule §129.5 (i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. Therefore, reimbursement for CPT codes 99213 and 99080 is recommended.

### Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$107.04.

### **PART VI: ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$107.04 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

**12/30/10**

\_\_\_\_\_  
Date

### **PART VII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**